

# 2015-2016 Provider Orientation

## South Carolina Department of Disabilities and Special Needs



June 17-18, 2015

**Presenter:**  
Monica Owens, Alliant ASO



## Quality Assurance Review Process



## Pre-Review Procedures

- ▶ Provider will receive:
  - Notification of upcoming review 2 weeks prior to scheduled review via email. The notification letter will include the review period of information to be reviewed.
  - List of all items needed for administrative portion of the review including the employee record sample



## Pre-Review Procedures (Cont'd)

- ▶ Provider will be requested to submit a complete employee list to Alliant within 48 hours of receipt of email



## Pre-Review Procedures (Cont'd)

- ▶ Provider will be requested to assemble information pertaining to the following entities prior to the entrance conference:
  - Human Rights Committee
  - Risk Management
  - Outlier
  - Verification of Analysis for Critical Incidence, Abuse and Death
  - Quarterly Residential Visits (Unannounced)
  - HASCI Rehabilitation Supports (if applicable)
  - Residential Admissions, Transfers and Discharges



## Entrance Conference

- ▶ Entrance conference will be conducted prior to record review
- ▶ Key staff members of the provider are asked to participate
- ▶ Points of Contact will be established for both the provider and Alliant



## Entrance Conference (Cont'd)

- ▶ Provider will receive the list of consumers to be reviewed. (For larger providers, additional lists may be provided as the review continues, depending upon the sample size)
- ▶ Provider will receive a list of selected employee records needed for the Administrative portion of the review
- ▶ Review Lead will discuss additional logistical issues regarding residential and day service observations and NCI Survey Interviews



## Administrative Review Requirements

The following items are needed to conduct the Administrative Review, which will begin immediately following the Entrance Conference:

- ▶ Personnel Records:
  - The Review Team will need documentation verifying compliance with standards, manuals and policies, as specified in A1-05 through A1-16 & A1-25, A2-01 through A2-03 as well as G10-15, G10-16, & G10-27 for PDD Case Managers.



## Administrative Review Requirements (Cont'd)

- Upon your receipt of the personnel list with the selected personnel files noted by the Lead Reviewer:
  - Ask a liaison from your HR Department to assist reviewers in locating information in the personnel records if needed



## Administrative Review Requirements (Cont'd)

- ▶ Information must be received within 1 hour of the end of the Entrance Conference, unless mutually agreed upon by Alliant and the provider administration during the entrance conference. Extensions will be considered for providers with Human Resource Offices in more than one location (multi-county). The approved extension for background check and training records will be noted in the Report of Findings comments.



## Administrative Review Requirements (Cont'd)

- ▶ Additional information needed to verify adherence with the Administrative Indicators:
  - Identification of Human Rights Committee members with their start dates, as well as identification of member composition
  - Verification of HRC initial training (for new members during review period) and tabbed ongoing training for all corrective actions
  - HRC Minutes



## Administrative Review Requirements (Cont'd)

- Risk Management/Safety Committee Meeting Minutes
- Verification of analysis of ANE, CI, & Death/impending death data and actions taken to prevent future ANE & CI and Death as applicable
- Database of recorded/tracked, analyzed, trended medication errors including corrective actions
- Database of recorded/tracked, analyzed, trended use of restraints



## Administrative Review Requirements (Cont'd)

- Documentation of follow-up for consumers referred for GERD/ Dysphagia Consultation.
- Outlier contracts including:
  - Approved staffing grids
  - Master schedule and corresponding verification/confirmation of staff coverage
  - Logs, etc.



## Administrative Review Requirements (Cont'd)

- Verification of quarterly visits to all homes by upper-level management (tabbed by home)
- A list of homes with names of their designated coordinators (staff responsible for the development and monitoring of residential plans)



## Administrative Review Requirements (Cont'd)

- Community Residential Admissions/Discharge/Transfer Reports with:
  - Verification the residential location has been changed on CDSS
  - A copy of the license for each applicable home, current for the date of the ADT.
  - The monthly census reports for the months of the admissions & transfers (Screenshot will be acceptable, showing consumer name and dates)
- Statements of Financial Rights for all residential admissions during the period in review



## Administrative Review Requirements (Cont'd)

- Verification that employees are made aware of False Claims Recovery Act & Whistleblower laws annually (verification will be reviewed for the personnel files selected for review)
- System for 24/7 access to assistance (Service Coordination providers only)

\*Administrative Review may be subject to the request of additional information





## Reconsideration Process

- ▶ A period of reconsideration will be established daily for the review
- ▶ Provider will be given an opportunity at that time to produce any items that may have not been available in the record at the time of review
- ▶ Once a record has been reconsidered for the day, it cannot be reconsidered
- ▶ If documentation is accepted for reconsideration, the citation will be removed



## Exit Conference

- ▶ Exit conference will be conducted at the end of the review
- ▶ A summary of the review along with the final debriefing of records and preliminary findings will be given at this time
- ▶ Provider will be asked to give the Review Lead information for any contact persons they wish to have included in the receipt of the Report of Findings



## Report of Findings and Plan of Correction

- ▶ Report of Findings will be posted to the Alliant portal within 30 days from the exit conference
- ▶ Report will be made available on the Alliant portal to designated provider staff
- ▶ Provider must submit completed Plan of Correction in its entirety via the portal within 30 days of report release date
- ▶ Provider must check the appeal box if appealing a citation within the Plan of Correction



## Report of Findings and Plan of Correction (Cont'd)

- ▶ Plans of Correction will be reviewed within 30 days of receipt
- ▶ If specific lines on the Plan of Correction are not approved, provider must resubmit the line within 5 days of notification



## Appeals

- ▶ Provider may appeal citations received during the QA Review within 30 days of receipt of the ROF
- ▶ The Provider may submit only one appeal request per cited indicator during the review cycle (i.e. an appeal can not be re-considered for appeal once a decision has been made by DDSN)



## Appeals (Cont'd)

- ▶ Provider must complete the DDSN Appeal Request Form that is located on the Alliant provider portal
  - Provider must attach supporting documentation with the Appeal Request Form
  - Both the Appeal Request Form and supporting documentation must be uploaded into the provider portal
- ▶ DDSN will provide a final ruling on the request



## Appeals (Cont'd)

- ▶ The Alliant management team will initially review the request and documentation and submit a recommendation to DDSN for final review within 30 days
- ▶ DDSN program staff will review the appeal request and the supporting documentation to make a determination to uphold or remove the citation and notify the provider of the outcome. The QIO will be advised of the outcome of the appeal so that future reviews will be conducted in accord with DDSN's decision.



## Appeals (Cont'd)

- ▶ Based on the results of the appeal, if needed, a revised report will be issued.
- ▶ A Plan of Correction for all citations must be submitted to the QIO within 30 days of the appeal decision. Corrections are required to be completed no later than 90 days after receiving the QIO report unless otherwise specified and subsequently approved by DDSN.



## Follow Up Reviews

- ▶ Follow-up reviews will be conducted approximately 180 days after the exit conference
- ▶ The follow-up review will focus only on those indicators that were found noncompliant during the regular review.
- ▶ The follow-up sample will consist of a minimum of the records cited during the Quality Assurance Review along with an equal number of new consumers
- ▶ In the event the indicators reviewed remain non-compliant, an additional Plan of Correction will be required and subsequent follow-up reviews will be scheduled



## New Indicators

**A1-17: Guidance revised** - For residential and day service providers: Review of any GERD/ Dysphagia Consultation reports to ensure there has been follow-up on recommendations during the provider's risk management meetings.

**A1-23: Guidance added** -The Provider shall conduct quarterly unannounced visits to all of its residential locations across all shifts excluding third shift in Community Training Home I and Supervised Living I Programs, including weekends, to assure sufficient staffing and supervision per the consumers' plans. Managers should not visit homes they supervise, but should visit homes managed by their peers.

**A1-24: Guidance added**- Do providers have a policy for security and access to electronic records?



## New Indicators

### **A1-30: Board / Provider follows procedure regarding Medication Technician Certification program as outlined in 603-13-DD**

**Guidance** - For Boards/ Providers utilizing Medication Technicians, the Board/ Provider is required to maintain the following records:

- Documentation that the Medication Technician Certification course was approved by DDSN Division of Quality Management
- A roster of all Medication Technicians employed with the Board/ Provider
- A Medication Technician Training certificate for each employee upon successful completion of the minimum 16 hour course



## New Indicators

### **A1- 30: Guidance cont.. –**

- A record of annual refresher class attendance (The refresher course must be on the administration of medication and no less than two (2) hour duration.) Documentation must include the instructor's name/ signature and title.
- A record of quarterly oversight sessions (Quarterly oversight should be tailored toward the needs of the agency and the medication technician.
- Documentation of the type of oversight and staff responsible must be maintain in a centralized location for each agency)

The QIO may pull a sample of Medication Technician files (current employees or those employed within the review period) to review for compliance with requirements outlined in the directive).

**Source: 603-13-DD**



## New Indicators

**G1-104: A valid Service Agreement is present and signed as appropriate**

**Guidance:** A valid Service Agreement (review most recently completed Service Agreement to assure that it is dated and signed.) For children and for adult's adjudicated incompetent, the current legal guardian (if applicable) must sign the form. For those 18 years and older or those with a name change, a new Service Agreement should be signed by the person. The most current Service Agreement that is signed and dated by the appropriate party must be filed in the primary case record.



## New Indicators

**G1-104 cont..** - Score "Not Met" if there is not a Service Agreement in the primary case record and/or it is not signed and dated by the appropriate party. If a person is unable to sign but can make their "mark", the mark must be witnessed. If a person is unable to sign or make their mark on the Service Agreement, there will be an explanation on the form and supporting documentation in the file.



## New Indicators

**G3- 03: *Guidance Added:*** If the consumer did not attend at least 10 days during the first 30 calendar days, then the assessment should be completed by the 10<sup>th</sup> day of attendance.

**G3-05: *Guidance Added:*** If the consumer did not attend at least 10 days during the first 30 calendar days, then the plan should be completed by the 10<sup>th</sup> day of attendance.



## New Indicators

**G3-12: *Guidance Revised:*** The word “objective” was added to bullet 1 and 2.

The Program Director’s or designee’s signature on the Monthly Data Recording Sheet or logged review of the ISP Program / ISP Data in Therap signifies that the training intervention(s) and objective(s) in the plan have been monitored.

An evaluation of progress for each training intervention/ objective must be noted.

If no progress is made over the previous month’s percentage, a comment is required on the Monthly Data Recording Sheet or in the ISP Program / ISP Data in Therap detailing the changes to the intervention or methods, or an explanation for the lack of progress and justification for continuing with the intervention and methods unchanged.





## New Indicators

**G3-13: Guidance Added:** NOTE: Amendments to paper plans must be made using a separate form identified as a plan amendment, indicating the date of the amendment, the name and date of birth, the reason for the amendment, and description of how the plan is being amended.  
Plans developed in Therap's ISP Programs do not require a paper amendment form but should reflect the reason for the change to the ISP Program.



## New Indicators

**G8- 08 W: Guidance Revised -** *Following bullets were added to section b.*  
 a face-to-face visit in the person's residence to gather information for the annual assessment,  
**a face –to-face contact with the person every 180 days in conjunction with the review/update of the Annual Assessment**



## New Indicators

**G8-16: Guidance Revised** - Effective 7/1/15: From the point that the assessment is complete and adequate to determine the level of care, the level of care must be determined, completed, and documented within 3 business days. There may be times when clarification of an applicant's medical condition or additional information is indicated and may interfere with the established timeframes. Any exceptions to these timeframes must be documented in the narrative.



## New Indicators

**G8-32: Authorized waiver services are suspended when the waiver participant is hospitalized or temporarily placed in an NF or ICF/IID**

**Guidance:** Review participants service notes and other documents to determine if participant was hospitalized or temporarily placed in a nursing facility or ICF/IID. If so, verify that the service coordinator suspended waiver services prior to facility placement. Waiver services allowed to pay due to incorrect/missing service suspension are subject to recoupment.

**NOTE: Not intended for Institutional Respite cases.**



## New Indicators

**G9-28R: Guidance Added-** Review participants service notes and other documents to determine if participant was hospitalized or temporarily placed in a nursing facility or ICF/IID. If so, verify that the service coordinator suspended waiver services prior to facility placement. Waiver services allowed to pay due to incorrect/ missing service suspension are subject to recoupment.

**NOTE: Not intended for Institutional Respite cases.**



## New Indicators

**G10-29R:** Authorized waiver services are suspended when the waiver participant is hospitalized or temporarily placed in an NF or ICF/IID

**Guidance:** Review participants service notes and other documents to determine if participant was hospitalized or temporarily placed in a nursing facility or ICF/IID. If so, verify that the service coordinator suspended waiver services prior to facility placement. Waiver services allowed to pay due to incorrect/ missing service suspension are subject to recoupment.

**NOTE: Not intended for Institutional Respite cases.**



## New Indicator

**G11-27R: *Guidance added*** - Review participants service notes and other documents to determine if participant was hospitalized or temporarily placed in a nursing facility or ICF/IID. If so, verify that the service coordinator suspended waiver services prior to facility placement. Waiver services allowed to pay due to incorrect/ missing service suspension are subject to recoupment.

**NOTE: Not intended for Institutional Respite cases.**



## New Indicator

**G12-01: *Guidance added*** - PPD Tuberculin Test

**G12-02: *Guidance added*** - PPD Tuberculin Test



## New Indicator

**G12-07:** Update assessments and modify the treatment plan as necessary.

**Guidance:** When service changes are identified as needed in the participant's waiver record but the Consultant fails to update the plan. Review all plans and service notes in effect during the review period to determine if:

- a) Updates are made when new service needs or interventions are identified,
- b) There have been significant changes in the child's life,
- c) A service is determined to not be effective,
- d) A need/s has/have been met,
- e) The parent is not satisfied,
- f) The child is uncooperative.



## New Indicator

**G12-08R: General requirements for all employees. These requirements must be met and evidence of such maintained by the Provider prior to the start of services.**

DSS Child Abuse Central Registry: The ABA Consultant, Lead and Line Therapist must have a clear background check to indicate that the employee is not listed in the South Carolina Department of Social Service (SCDSS) Child Abuse Central Registry. This must be reconfirmed annually with the results obtained before the current notification expires. All names are to be submitted to DSS using Consent to Release Information (SCDSS Form 3072).



## New Indicator

**G12-08 R Guidance cont.:** South Carolina Law Enforcement Division/Sexual Offender Registry: The ABA Consultant, Lead and Line Therapist must have clear background check to indicate that the employee is not listed in the South Carolina Law Enforcement Division/Sexual Offender Registry. This must be reconfirmed annually with the results obtained before the current notification expires.

South Carolina Law Enforcement Division Criminal Background Check: The ABA Consultant, Lead and the Line Therapist must have clear background check to indicate that the employee is not listed as having a felony conviction as determined by an officially obtained SLED report. This must be conducted annually with the results obtained before the current notification expires.



## New Indicator

**G12-08R Guidance cont.:** Driver's License: The ABA Consultant, Lead and Line Therapist must provide a copy of current, valid driver's license that must be submitted annually by the anniversary date. If no driver's license, submit a copy of an Official State ID Card.

PPD Tuberculin Test: The ABA Consultant, Lead and Line Therapist must have a negative PPD TB Test result. Please refer to South Carolina Department of Health and Environmental Control (SCDHEC) website, Regulation 61-75 – Standards for Licensing page 11 of 36 section b. 1-6 for PPD Tuberculin test requirements.



## New Indicator

**G12-08R: *Guidance cont..* - Documentation of Training: The ABA Consultant, Lead and Line Therapist must have documentation of receiving annual in-service training of at least twelve (12) hours. Annual training must occur before the current training expires. Topics may vary from the initial training but must include the child's Individualized EIBI program. At least fifty per cent (50%) of this training must be facilitated face to face and provide validation of skills through demonstration and a post test.**



## New Indicator

**E1-08: *Guidance revised* - Review the Summary of Services/Planned Services page of the IFSP to ensure that all Baby Net services being received are listed**

**E1-10: *Guidance revised* - Review the IFSP Planned Service section and Service Notes to determine if services began within 30 days of identification, if there was a provider available.**



## New Indicator

**E1-16: *Revision to Indicator* - Assessments are completed every 180 days ~~6 months~~ or as often as changes warrant**

**Guidance revision** - Review assessment dates on chosen assessment tool(s) and IFSP to ensure they are completed every 180 days ~~6 months~~ or as changes warrant (i.e., significant improvement or regression).



## New Indicator

**E1-17: *Guidance Revision* -** The IFSP should outline the frequency of Family Training. Review the Family Training summary sheets, IFSP Summary of Services/Planned services section, to ensure that FT is provided at the frequency and duration outlined. If the frequency and duration outlined is not being provided consistently, review Service Notes and other documentation to see if the EI is attempting to follow the schedule.

If the parent/caregiver cancels the visit the EI does NOT have to offer to make the visit up.





## New Indicator

**E2-13: *Guidance revision***- If the child is 2.6 years or older review Services Notes, transition ~~page~~ section of the IFSP, and a copy of the transition referral to ensure the referral was sent by the time the child was 2.6 years old.



## New Indicator

**E2-19: *Indicator revision*** - Assessments are completed every 180 days ~~6 months~~ or as often as changes warrant

***Guidance revision*** - Review assessment dates on chosen assessment tool(s) and IFSP to ensure they are completed every 180 days ~~6 months~~ or as changes warrant (i.e., significant improvement or regression).

**E2-20: *Guidance revision*** - If the parent/caregiver cancels the visit the EI does NOT have to offer to make the visit up.



## New Indicator

**E3-13: *Guidance revision*** - The FSP "Other Services" ~~worksheet~~ must be in all EI files section must reflect current services (Waiver, Center based child care, OT, ST, PT, FT amount, frequency, and duration, Family Support Funds, Respite, ABC, etc.).

**E3-15: *Indicator revision*** - Assessments are completed every 180 days ~~6 months~~ or as often as changes warrant

***Guidance revision*** - Review assessment dates on chosen assessment tool(s) and IFSP to ensure they are completed every 180 days 6 months or as changes warrant (i.e., significant improvement or regression).



## New Indicator

**E3-16: *Guidance revision*** - If the parent/caregiver cancels the visit the EI does NOT have to offer to make the visit up



## FY 16 Recoupable Indicators

### Administrative

A1-07  
A1-09  
A1-12

A1-08  
A1-10



## FY 16 Recoupable Indicators

### General Agency

G8-01  
G8-07  
G8-17  
G8-23  
G8-28  
G8-101  
G8-103  
G8-105  
G8-107  
G8-111

G8-03  
G8-16  
G8-21  
G8-27  
G8-32  
G8-102  
G8-104  
G8-106  
G8-109



## FY 16 Recoupable Indicators

### General Agency

G9-01	G9-02
G9-09	G9-14
G9-20	G9-21
G9-22	G9-25
G9-27	G9-28
G9-29	G9-101
G9-102	G9-103
G9-104	G9-105
G9-106	G9-107
G9-109	G9-111



## FY 16 Recoupable Indicators

### General Agency

G10-01	G10-04
G10-09	G10-10
G10-12	G10-15
G10-16	G10-20
G10-28	G10-29
G10-101	G10-102
G10-103	G10-104
G10-105	G10-106
G10-107	G10-109
G10-111	



## FY 16 Recoupable Indicators

### General Agency

G11-01	G11-02
G11-09	G11-14
G11-20	G11-21
G11-22	G11-26
G11-27	G11-28
G11-29	G11-101
G11-102	G11-103
G11-104	G11-105
G11-106	G11-107
G11-109	G11-111



## FY 16 Recoupable Indicators

### General Agency

G12-01	G12-02
G12-03	G12-08

### Early Intervention

E1-04	E2-04
E3-05	



## Questions?



## Licensing Reviews

- ▶ Reviews will be conducted annually for SLP II, CTH I, CTH II, CLOUD, and Respite homes as well as Day Service programs
- ▶ Providers will receive notification of their upcoming review 24 hours prior to the scheduled review. Providers are expected to have a staff available at the home at the scheduled time.
- ▶ Reviews will be based upon DDSN Residential, Day Service, and Respite Standards



## Residential Required Items

- ▶ Current MARs
- ▶ Past MARs (90 days)
- ▶ Most recent fire marshal inspection
- ▶ Policy for disposition of medication
- ▶ Medication error rate by facility



## Day Service Required Items

- ▶ Fire and disaster drills for the last year
- ▶ Policy addressing alternate coverage for staff members who are ill
- ▶ Most recent fire marshal, electrical systems, HVAC, and sprinkler system inspections
- ▶ Monthly vehicle maintenance records
- ▶ Written authorization for consumers to be administered medication



## Day Service Required Items (Cont'd)

- ▶ Staff defensive driver training and fire safety training (including proper use of fire extinguishers)
- ▶ Daily vehicle checklists
- ▶ Current and past MAR's (past 90 days)
- ▶ Policy for disposition of medication



## Entrance Conference

- ▶ Entrance conference will be conducted prior to facility review
- ▶ Key staff members of the provider are asked to participate
- ▶ Points of contact will be established for both the provider and Alliant
- ▶ Provider will be asked to submit the previously requested documentation





## Exit Conference

- ▶ Exit conference will be conducted at the end of the review
- ▶ A summary of the review including preliminary citations will be provided at this time



## Report of Findings and Plan of Correction

- ▶ Report of Findings will be posted to the Alliant portal within 30 days from the exit conference
- ▶ Report will be made available on the Alliant portal to designated provider staff
- ▶ Provider must submit completed Plan of Correction in its entirety via the portal within 15 days of report release date
- ▶ Provider must check the appeal box if appealing a citation within the Plan of Correction



## Report of Findings and Plan of Correction (Cont'd)

- ▶ Plans of Correction will be reviewed within 30 days of receipt
- ▶ If specific lines on the Plan of Correction are not approved, provider must resubmit the line within 5 days of notification



## Appeals

- ▶ Provider may appeal any citation received during the Licensing Review within 15 days of the ROF
- ▶ Provider must complete the DDSN Appeal Request Form which is located on the Alliant provider portal
- ▶ Provider must attach supporting documentation with the Appeal Request Form
- ▶ Both the Appeal Request Form and supporting documentation must be uploaded into the provider portal



## Appeals (Con't)

- ▶ The Alliant management team will initially review the request and documentation
- ▶ The Alliant management team will submit a recommendation to DDSN for final review
- ▶ DDSN will provide a final ruling on the request within 30 days
- ▶ Provider will be notified once an appeals decision has been reached and the outcome has been posted to the portal for their review



## Follow-up Reviews Licensing

- ▶ A follow-up review will be conducted approximately 180 days after the exit conference
- ▶ The follow-up review will consist of citations noted during the Licensing Review **to ensure the successful implementation of the Plan of Correction. This follow-up may be via desk review or onsite.** For desk reviews, providers will be requested to submit supporting documentation within 2 business days.



## Follow-up Reviews Licensing (Con't)

- ▶ For multiple citations for the same indicator, there may be a combination of a desk and onsite review.
- ▶ In the event the indicators reviewed remain noncompliant, an additional Plan of Correction will be required and subsequent follow-up reviews will be scheduled



## Questions?



MAKING HEALTH CARE BETTER